Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ROBERT E. URREA, MD
6211 EDGEMERE STE 1
EL PASO, TX 79925

Respondent Name

NATIONAL AMERICAN INSURANCE CO

Carrier's Austin Representative Box

Box Number 01

MFDR Tracking Number

M4-11-3558-02

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached Medical Fee Dispute is being filed because the Insurance Carrier is denying this claim as timely filing...On Jan. 19, 2011 we called to check status on the claim for the assistant Casey informed us that the claim was not in the system and to resend the claim for processing. Proof of timely filing is highlighted in Box 31."

Amount in Dispute: $915.35

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The disputed date of service was first received by the carrier on 1/27/2011. Timely filing for these dates of service expired on 1/18/2011. The HCP has failed to provide any acceptable proof of timely filing such as a fax transmittal, or a signed receipt from the carrier to support their stance that the claim was filed timely. "

Response Submitted by: National American Insurance Co., P.O. Box 38, Chandler, OK 74834

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
October 14, 2010	CPT code 63030-80	$915.35	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §133.20 sets out the procedures for health care providers to submit workers'

compensation medical bills for reimbursement.

3. 28 Texas Administrative Code §102.4 sets out the rules for Non-Commission Communications.
4. Texas Labor Code §408.027 sets out the rules for timely submission of a claim by a health care provider.
5. Texas Labor Code §408.0272 sets out the rules for certain exceptions for untimely submission of a claim by a health care provider.
6. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated April 7, 2011
   - 29-Time limit for filing claim/bill has expired
   - 193-Original payment decision maintained

   Explanation of benefits dated May 12, 2011
   - 168-No additional allowance recommended
   - 29-Time limit for filing claim/bill has expired
   - 193-Original payment decision maintained

Issues

1. Did the requestor submit the medical bill for the services in dispute timely and in accordance with 28 Texas Administrative Code §133.20?
2. Did the requestor submit documentation to support the disputed bills were submitted timely in accordance with Texas Labor Code, Section §408.027 and 28 Texas Administrative Code §102.4?
3. Is the requestor entitled to reimbursement?

Findings

1. Pursuant to 28 Texas Administrative Code §133.20(b) states in pertinent part "Except as provided in Texas Labor Code §408.0272…a health care provider shall not submit a medical bill later than the 95th day after the date the services are provided." No documentation was found to support that Texas Labor code §408.0272 applies to the service in dispute, for that reason, the health care provider and requestor in this dispute were required to send the medical bill no later than 95 days after the service in dispute was provided. 28 Texas Administrative Code §102.4(h) states "Unless the great weight of evidence indicates otherwise, written communications shall be deemed to have been sent on: (1) the date received, if sent by fax, personal delivery, or electronic transmission or, (2) the date postmarked if sent by mail via United States Postal Service regular mail, or, if the postmark date is unavailable, the later of the signature date on the written communication or the date it was received minus five days. If the date received minus five days is a Sunday or legal holiday, the date deemed sent shall be the next previous day which is not a Sunday or legal holiday."
2. Review of the requestor's submitted documentation finds two Explanation of Benefits with audit dates, April 7, 2011 and May 12, 2011, two copies of a medical bill with printed date 12/02/10 and 01/19/11 in box 31 and an appeal letter dated April 22, 2011. No documentation was found to sufficiently support that the requestor submitted a bill within 95 days from the date services were provided in accordance with 28 Texas Administrative Code §133.20(b) and §102.4.
3. In Accordance with Texas Labor Code §408.027, the requestor in this medical fee dispute has forfeited the right to reimbursement due to untimely submission of the medical bill for the services in dispute.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

		01/13/2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.